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Annual Report to

**THE NORTH CAROLINA JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON  
MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE  
ABUSE SERVICES**

on

***Deaths Reported and Facility Compliance with Restraint and Seclusion  
Policies and Procedures in State Fiscal Year 2006-07***

as originally required by SL 2000-129, Section 3(b), 5(b) and 6(b)  
and as amended by SL 2003-58, Sections 1-4

Submitted by

Department of Health and Human Services

Division of Health Service Regulation  
Division of Mental Health, Developmental Disabilities, and Substance Abuse Services

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## ***Deaths Reported and Facility Compliance With Restraint and Seclusion Policies and Procedures in State Fiscal Year 2006-07***

### **INTRODUCTION**

Section 3(b), 5(b) and 6(b) of Session Law 2000-129 (House Bill 1520), as amended by Sections 1-4 of Session Law 2003-58 (House Bill 80), requires the Department of Health and Human Services to report annually on the first day of October to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Services on the following for the immediately preceding fiscal year:

- The number of facilities that reported deaths under G.S. 122C-31, G.S. 131D-10.6, and G.S. 131D-34.1, the number of deaths reported by each facility, the number of deaths investigated pursuant to these statutes, and the number of deaths found by investigation to be related to the use of restraint or seclusion.
- The level of compliance of certain facilities with applicable State and Federal laws, rules, and regulations regarding the use of restraints and seclusion. This include the most and least frequently reported citations for noncompliance with restraint/seclusion policies and procedures.

This report is a compilation of data provided by these facilities in addition to deficiency information from monitoring reports, surveys and investigations conducted by staff under the NC Department of Health and Human Services (Department) staff. **All of the data in this report is for State Fiscal Year (SFY) 2006-2007 (July 1, 2006 through June 30, 2007).**

### **DEATH REPORTING**

Session Law 2000-129, which amended G.S. 122C-31, 131D-10.6B and 131D-34.1, requires certain types of facilities to notify the Department of any death of a consumer that:

- Occurred within seven days of use of physical restraint or physical hold; or
- Resulted from violence, accident, suicide or homicide.

Regulations in 10A NCAC 26C Section .0300 implement death reporting requirements of these laws and provide specific instructions to facilities for reporting deaths.

- **Facilities licensed** in accordance with G.S. 122C, Article 2, **State facilities** operating in accordance with G.S. 122C Article 4, Part 5 and **inpatient psychiatric units** of hospitals licensed under G.S. 131E shall report consumer deaths to the **Division of Health Service Regulation (DHSR), formerly the Division of Facility Services**.
- **Facilities not licensed** in accordance with G.S. 122C, Article 2 and not State facilities operating in accordance with G.S. 122C Article 4, Part 5 shall report client deaths to the **Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS)**.

All deaths reported to the Department were screened to determine if an investigation is warranted. The primary purpose of the screening and any subsequent investigation was to determine if the facility was culpable in the consumer's death. For purposes of this report, the outcome of the investigation was limited to whether the death occurred as a result of restraint, physical hold, or seclusion.

The following are eight tables which list facilities addressed by the general statutes on page three. The first five tables provide information on deaths reported by private facilities. The next three tables provide information on deaths reported by state facilities. These tables identify the number of deaths that were: 1) reported and screened; 2) investigated; and 3) found by the investigation to be related to the facility's use of physical restraint, physical hold, or seclusion. The first part of this report concludes with a summary of deaths reported for the private and state facilities.

## DEATHS REPORTED BY PRIVATE FACILITIES

Tables 1-5 display data on deaths at private facilities subject to reporting requirements in G.S. 122C-31, 131D-10.6B and 131D-34.1, namely deaths that occurred within seven days of restraint, physical hold, or seclusion, or were the result of violence, accident, suicide or homicide. These tables do not include deaths that were voluntarily reported to the Department and resulted from other causes.

**Table 1: Deaths Reported by Private Licensed Assisted Living Facilities<sup>1</sup>**

County	Facility	# Deaths Reported and Screened	# Reports Investigated <sup>2</sup>	# Investigations Finding Death Related to Restraint/Hold <sup>3</sup>
Alamance	Alvarado's Family Care Home	1	1	0
Bladen	Bladenboro Assisted Retirement	1	0	0
Brunswick	Eldo Family Care Home #1	1	0	0
Cabarrus	Concord Place	2	0	0
Caldwell	Carolina Oaks Enhanced Care	1	1	0
Catawba	Hickory Manor	1	0	0
Chatham	Cambridge Hills of Pittsboro	1	0	0
Cleveland	Unique Living	1	1	0
Cumberland	Len-Care of Cedar Creek	1	0	0
	Pine Valley	1	0	0
	Hope Mills Retirement Center	1	0	0
Durham	Carolina House of Chapel Hill	1	0	0
Gaston	Gaston Place	1	0	0
	Abingdon Place of Gastonia	1	0	0
Guilford	Friendship Care	1	0	0
	Wesleyan Arms Retirement Center	1	0	0
	Oak Hill Rest Home	1	0	0
	Carriage House Senior Living	2	0	0
Harnett	Primrose Villa Retirement III	1	1	0
Henderson	Heritage Lodge	1	0	0
	Soundview Family Care – Unit E	1	0	0
	Cherry Springs Village	1	0	0
Hertford	Carver Manor	1	1	0
	Pinewood Manor	2	0	0

**Table 1: Deaths Reported by Private Licensed Assisted Living Facilities<sup>1</sup>  
(Continued)**

County	Facility	# Deaths Reported and Screened	# Reports Investigated <sup>2</sup>	# Investigations Finding Death Related to Restraint/Hold <sup>3</sup>
Iredell	Southland Homes, Inc./Olin Village	1	0	0
Martin	Vintage Inn	4	0	0
Mecklenburg	The Little Flower Assisted Living	1	0	0
	Weddington Park	1	0	0
Moore	Michael Lane/Alternative House	1	0	0
New Hanover	Hermitage House Rest Home	2	0	0
Onslow	Brown's Family Care Home	1	0	0
	Pearl's Family Care Home #2	1	1	0
Pitt	Oak Haven Assisted Living	1	0	0
Randolph	Carolina House of Asheboro	1	0	0
Richmond	Somerset Court	1	0	0
Robeson	Hermitage Retirement Center	1	0	0
Rockingham	Carolina House of Reidsville	1	0	0
Rutherford	Union Mills Center #1	1	1	0
	Union Mills Center #2	1	1	0
Wake	Atwater Rest Home	1	0	0
	Pinetree Villa	1	0	0
	Parkway Retirement Home	1	1	1
	Sunrise Assisted Living at North Hills	1	1	0
Wayne	Wayne County Rest Villa #1	1	0	0
Wilkes	The Villages of Wilkes	3	1	0
<b>Total</b>	<b>Facility Count: 45</b>	<b>54</b>	<b>11</b>	<b>1</b>

**NOTES:**

1. There were 1,285 of these facilities, with a total of 39,896 beds.
2. For these facilities, the investigation is initiated by a referral of the death report to the County Department of Social Services by DHSR Complaint Intake Unit after screening.
3. Shading in this column indicates that either an investigation was not warranted, or the result of the investigation determined that the death was not due to restraint or physical hold.

**Table 2: Deaths Reported by Private Group Homes, and Outpatient and Day Treatment Facilities<sup>1</sup>**

County	Facility	# Deaths Reported and Screened	# Reports Investigated	# Investigations Finding Death Related to Restraint/Hold <sup>2</sup>
Buncombe	Western Carolina Treatment	1	0	0
Cumberland	Cumberland County MH	1	0	0
Greene	Indianhead	1	1	0
Guilford	Sanctuary House	2	0	0
New Hanover	Coastal Horizons	1	0	0
	New Visions	1	0	0
Robeson	Tanglewood Arbor	1	0	0
Rowan	Alternatives Counseling	1	0	0
	Stokes Ferry Group Home	1	1	0
Wake	Goshawk Lane	1	1	0
	Raynor Road	1	1	0
Watauga	New River Area MH	1	0	0
<b>Total</b>	Facility Count: 12	<b>13</b>	<b>4</b>	<b>0</b>

**NOTES:**

1. There were 3,634 of these facilities, with a total of 13,865 beds.
2. Shading in this column indicates that either an investigation was not warranted, or the result of the investigation determined that the death was not related to restraint or physical hold.

**Table 3: Deaths Reported by Private Intermediate Care Facilities for the Developmentally Disabled<sup>1</sup>**

County	Facility	# Deaths Reported and Screened	# Reports Investigated	# Investigations Finding Death Related to Restraint/Hold <sup>2</sup>
Buncombe	Blue Ridge Homes-Madison	1	0	0
<b>Total</b>	Facility Count: 1	<b>1</b>	<b>0</b>	<b>0</b>

**NOTES:**

1. There were 228 of these facilities with a total of 2,692 beds.
2. Shading in this column indicates that either an investigation was not warranted, or the result of the investigation determined that the death was not related to restraint or physical hold.

**Table 4: Deaths Reported by Private Psychiatric Treatment Facilities<sup>1</sup>**

County	Facility	# Deaths Reported and Screened	# Reports Investigated	# Investigations Finding Death Related to Restraint/Hold <sup>2</sup>
Duplin	Duplin General Hospital	1	1	0
Forsyth	N.C. Baptist Hospital	1	0	0
Henderson	Margaret R. Pardee Hospital	1	1	0
	Park Ridge Hospital	1	0	0
<b>Total</b>	Facility Count: 4	<b>4</b>	<b>2</b>	<b>0</b>

**NOTES:**

1. There were 6 private psychiatric hospitals, 40 hospitals with acute care psychiatric units, 15 psychiatric residential treatment facilities, 4 wilderness camps, and 8 foster care camps, with a total of 2,986 beds.
2. Shading in this column indicates that either an investigation was not warranted, or the result of the investigation determined that the death was not related to restraint or physical hold.

**Table 5: Deaths Reported by Certain Unlicensed Private Facilities<sup>1</sup>**

County	Facility	# Deaths Reported and Screened	# Reports Investigated <sup>2</sup>	# Investigations Finding Death Related to Restraint/Hold <sup>3</sup>
Alamance	Triumph, LLC	1	1	0
Anson	MHA in NC- Stanley	1	1	0
Ashe	New River Behavioral Health	1	1	0
Avery	New River Behavioral Health	2	2	0
Bladen	Coordinated Health Services	1	1	0
Buncombe	Ona's Place	1	1	0
	Mental Health Assoc.- Buncombe	1	1	0
Catawba	Family NET	1	1	0
	Catawba Valley Behavioral Health	1	1	0
Cleveland	Footprints Carolina	1	1	0
Columbus	Family Alternatives, Inc	1	1	0
Craven	Port Human Services	1	1	0
Cumberland	Carolina Treatment Center	1	1	0
	Professional Family Care Services	1	1	0
	Cumberland Co Mental Health Ctr.	1	1	0
Durham	Triumph LLC	2	2	0
	Covenant Community Partners	1	1	0
Forsyth	Daymark Recovery Services	2	2	0
	United Youth Care Services Inc.	1	1	0
	Triumph LLC	1	1	0
Gaston	Footprints Carolina	1	1	0

**Table 5: Deaths Reported by Certain Unlicensed Private Facilities (Continued)**

County	Facility	# Deaths Reported and Screened	# Reports Investigated <sup>1</sup>	# Investigations Finding Death Related to Restraint/Hold <sup>2</sup>
Guilford	Central States of the Carolinas	1	1	0
	The Guilford Center	3	3	0
	Alcohol & Drug Services-East (TASC)	1	1	0
Halifax	Premier Family Healthcare	1	1	0
Lincoln	Footprints Carolina	1	1	0
Mecklenburg	Life Enhancement Services	1	1	0
Nash	Easter Seals/ UCP/ ASAP	1	1	0
New Hanover	Alpha Omega Health	1	1	0
Onslow	CNC/Access/Health Services Personnel	1	1	0
Orange	UNC Oasis Program	1	1	0
Person	Caring Family Network	1	1	0
	Eastern Carolina Case Management	1	1	0
Randolph	MHA in Randolph	1	1	0
	Sandhills MH- Randolph Services	2	2	0
Robeson	Behavioral Link	1	1	0
	MHA/ NC-Southeastern Regional	2	2	0
	Carolina Professional Mental Health	1	1	0
Rowan	Mental Health Association in NC	1	1	0
Sampson	Alternative Care Treatment System	1	1	0
Scotland	Coordinated Health Services	1	1	0
Union	Daymark Recovery Services, Inc.	2	2	0
Wake	Wake County Human Services	4	4	0
	Integrated Family Solutions,Ilc.	1	1	0
Watagua	New River Behavioral Healthcare	1	1	0
Wilkes	New River Behavioral Healthcare	1	1	0
<b>Total</b>	Facility Count: 46	<b>57</b>	<b>57</b>	<b>0</b>

**NOTES:**

1. This chart includes private facilities not licensed in accordance with G.S. 122C, Article 2; however, it does not include state facilities operating in accordance with G.S. 122 C Article 4, Part 5.
2. All of the deaths annotated in this column were investigated by the responsible Local Management Entity (LME) providing oversight, and the findings were reviewed by DMH/DD/SAS.
3. Shading in this column indicates that either an investigation was not warranted, or the result of the investigation determined that the death was not related to restraint or physical hold.

## DEATHS REPORTED BY STATE FACILITIES

Since 2001, state facilities have been required to report all deaths to the Division of Facility Services (now the Division of Health Service Regulation). Thus, the following tables include data on deaths that:

- resulted from natural causes;
- occurred within seven days of use of physical restraint or physical hold; and
- resulted from violence, accident, suicide or homicide.

**Table 6: Deaths Reported by State Intermediate Care Facilities for the Developmentally Disabled<sup>1</sup>**

County	Facility	# Deaths Reported and Screened	# Reports Investigated	# Investigations Finding Death Related to Restraint/Hold <sup>2</sup>
Burke	Riddle Developmental Ctr.	1	0	0
Granville	Murdoch Center	8	0	0
Lenoir	Caswell Center	11	0	0
Wayne	O'Berry Center	4	0	0
<b>Total</b>	Facility Count: 4	<b>24</b>	<b>0</b>	<b>0</b>

**NOTES:**

1. These 4 facilities had 1,802 operational beds.
2. Shading in this column indicates that either an investigation was not warranted, or the result of the investigation determined that the death was not related to restraint or physical hold.

**Table 7: Deaths Reported by State Psychiatric Hospitals<sup>1</sup>**

County	Facility	# Deaths Reported and Screened	# Reports Investigated	# Investigations Finding Death Related to Restraint/Hold <sup>2</sup>
Burke	Broughton Hospital <sup>3</sup>	4	2	0
Granville	John Umstead Hospital	1	0	0
Wake	Dorothea Dix Hospital	3	0	0
Wayne	Cherry Hospital	3	2	0
<b>Total</b>	Facility Count: 4	<b>11</b>	<b>4</b>	<b>0</b>

**NOTES:**

1. There were 4 of these facilities with 1,297 operational beds.
2. Shading in this column indicates that either an investigation was not warranted, or the result of the investigation determined that the death was not related to restraint or physical hold.
3. The figures cited for Broughton Hospital include a death that occurred in February, 2007. This death is one of the 4 deaths that were reported and screened. It is also one of the two deaths reported and screened that were investigated. The initial investigation in April of 2007 did not find that this death was related to a restraint/hold. A subsequent investigation in August of 2007 found that the death was related to a restraint/hold. The results of the August investigation will be reported in the SFY 2007-2008 report.

**Table 8: Deaths Reported by State Alcohol and Drug Abuse Treatment Centers<sup>1</sup>**

County	Facility	# Deaths Reported and Screened	# Reports Investigated	# Investigations Finding Death Related to Restraint/Hold <sup>2</sup>
	No deaths reported for these facilities			
<b>Total</b>	Facility Count: 0	<b>0</b>	<b>0</b>	<b>0</b>

**NOTES:**

1. There were 3 of these facilities, with a total of 236 beds.
2. Shading in this column indicates that either an investigation was not warranted, or the result of the investigation determined that the death was not related to restraint or physical hold.

**SUMMARY ON DEATHS REPORTED FOR SFY 2006-2007**

A total of 108 private facilities and eight state facilities reported 164 deaths:

- 129 of these deaths were reported by private facilities; and
- 35 of these deaths were reported by state facilities.

Of the 129 deaths reported by private facilities:

- 129 deaths were screened;
- 74 deaths were investigated; and
- One death was found to be related to restraint or physical hold.

Of the 35 deaths reported by state facilities:

- 35 deaths were screened;
- 4 deaths were investigated; and
- No deaths were found to be related to restraint or physical hold.

The following corrective actions were taken in response to the one death that was found to be related to restraint/physical hold:

- The facility was given a citation for non-compliance with restraint/seclusion policies and procedures; and
- Appropriate corrective actions were developed, and follow-up monitoring was conducted to verify that these corrective actions were implemented.

## COMPLIANCE WITH RESTRAINT/SECLUSION POLICIES AND PROCEDURES

Session Laws 2000-129 and 2003-80 require the Department to report each year on facility compliance with restraint and seclusion policies and procedures. The data in this section were collected from on-site investigations, inspections and monitoring visits.

The Division of Health Service Regulation (DHSR) conducted almost twice as many on-site visits this year than in previous years. This was due to the addition of 23 new staff to the Mental Health Licensure & Certification Section over the past two years, and to revision and streamlining of survey protocol. All of these factors resulted in a greater number of restraint/seclusion citations being reported for the past fiscal year.

Tables 9-16 show the number of citations for noncompliance with restraint, physical hold, and seclusion policies and procedures at private and state facilities. Tables 17 and 18 list the most and least frequently reported citations. The second part of this report concludes with a summary of restraint/seclusion citations for the facilities.

### Restraint/Seclusion Citations Reported for Private Facilities

**Table 9: Citations Reported for Private Licensed Assisted Living Facilities**

County	Facility	# Citations
Ashe	Jefferson Care Center	2
Buncombe	Evergreen Living Home #13	1
Burke	Longview Assisted Living	1
Caswell	Jefferson Care Home	1
Duplin	Golden Care	1
Durham	Durham Ridge Assisted Living	1
	Friendly Rest Home	1
Edgecombe	Britthaven of Tarboro	1
Haywood	Queen Retirement Home	1
Hertford	Twin Oaks Family Care Home	1
Montgomery	Starmont Assisted Living	1
Nash	Spring Arbor of Rocky Mount	2
Northampton	Rich Square Villa	1
Rutherford	Colonial Manor Rest Home	1
Wake	Aversboro Assisted Living	1
	Parkway Retirement Home	1
Wayne	Britthaven of LaGrange	1
<b>Total</b>	Facility Count: 17	<b>19</b>

**Table 10: Citations Reported for Private Group Homes, and Outpatient and Day Treatment Facilities**

County	Facility	# Citations
Alamance	United Care Center #2	4
Avery	Grandfather Home for Children	1
Bertie	Rayann House	2
Brunswick	Birges Home	1
Buncombe	First Step Farm - Men	1
	First Step Farm - Women	1
	Jimmy's House	2
	Lion's Cottage	1
	Temperance House	1
Burke	East Burke House	1
	Flynn Christian Fellowship	1
	Southmont Children	1
Cabarrus	Devereaux Home	1
	James Place	2
	Landon Home	1
	Old Charlotte	2
	Valley Home II	1
	YASD-Morehead	2
	Youth/Adult Care Management	1
	Youth Care LLC	2
Caldwell	Caldwell House	1
Catawba	Catawba County Group Home	1
	Houston and Odom Cottages	2
	Tyndall Center-Early Child	1
Cleveland	Carpenter House	1
	Uniquely Supported #2	1
	Uniquely Supported #3	1
	Uniquely Supported #5	1
	Uniquely Supported #6	1
	Uniquely Supported #7	1
	Uniquely Supported #8	1
	Uniquely Supported #9	1
	Uniquely Supported #10	1
	Uniquely Supported #11	1
	Uniquely Supported #13A	2
	Uniquely Supported #13B	1
	Voca - Cherryville Home	1
Columbus	Rosberry Home of Fairmont	5
Cumberland	A Positive Life	1
	Ashton W. Lilly Home	2
	Building Joy in Health Care	1
	Diyah's	1
	Diyah's #2	1
	Golden Opportunity Home #2	1
	Living Water Group Home	1
	Miracle of Faith	1
	Q&S	1
	Rainbow of Sunshine	1

**Table 10: Citations Reported for Private Group Homes, and Outpatient and Day Treatment Facilities (Continued)**

County	Facility	# Citations
Cumberland (Continued)	Shepard's House	1
	Shining Star	4
	Soteria	1
	Sunflower House	1
	Visions Residential Health Care	2
	Woodbridge At Lazybrook	1
Davidson	Fairview House	1
	Hasty House	2
	McLaurin Home	2
Durham	Abundance Safe Haven Inc / Boys	1
	Abundance Safe Haven Inc / Girls	2
	Anacosta Inc	3
	New Horizons	2
	Southlight Inc	2
	The Durham Family Care Home	1
Franklin	Sweetom's	1
Forsyth	Aldersgate Cottage	2
	Davis House at Bethabara	2
	Eldorada	1
	Garvins Mental Management	1
	Grandfather Home for Children	1
	Rock's Home	2
	The Vision House for Girls	2
Gaston	Assured Resource Environment	1
	Clay/Hickory Creek	1
	Cornerstone Christian Center	1
	The Essential Home #2	1
	The House of David	1
	The Trenton House	2
	The Green House	2
Granville	Tyler's Place	3
Greene	Edwards Group Home	1
	Edwards Group Home #3	2
	Hopewell	1
Guilford	A Brighter Tomorrow Group Home	3
	Austin's Place	2
	Benton Lane	1
	Brighter Path Family Care #1	1
	Britton Street Group Home	1
	Bryson's Place	3
	Cam House	2
	Dee's Home Care	1
	Ezcare Providers (Vida Home)	2
	Genesis Professionals, LLC	3
	GHHM - Northridge	2
	Good Shepard Family Care	2
	Hampton Drive Group Home	2
	Haven Group Home	2
	Health Ridge Group Home	1

**Table 10: Citations Reported for Private Group Homes, and Outpatient and Day Treatment Facilities (Continued)**

County	Facility	# Citations
Guilford (Continued)	Highland Hills	2
	James El Parrish	1
	Liggins – Sedalia	1
	McDowell Home	1
	Miracles of Faith Family Care	1
	One More Chance	1
	RJ Whitsett	1
	Shady Pine Group Home	1
	Spring House	3
	Woodmere Center	1
	Youth Focus	1
Haywood	Balsam Road	2
Henderson	Dogwood Acres	2
	Jimmy's House	2
	Laurel Park Group Home	1
Hoke	Bahia Home	3
	Forever Young Secured Community	1
	McEachin Treatment Facility	2
	New Horizon's Group Home, LLC	1
Iredell	Twin Oaks Group Home	1
	Mulberry Group Home	1
Johnston	Brogden	1
	Cornerstone Residential Services	2
	Serenity Falls – Jada House	2
Lee	Promise House	1
	Stoney Hill Residential	1
Lenoir	Ackerman House	1
	Corprew and Cox	1
	Hardee Road Group Home	1
	Nova	1
Lincoln	Boger City House	1
Mecklenburg	Lincoln Children's Home	3
	Turner 3	1
	Alexander Children's Home – Barnhardt	3
	Bodie Group Home	1
	David Kersey Home	1
	Family Support Services	2
	FSS/Enfield	1
	Jackson Family Home	1
	New Beginnings – Bark Mead	1
	New Life Central	2
	Promise Keepers	2
	Second Chance for You	1
	Tarheels Residential Treatment	2
	The Keys of Carolina	3
	United Treatment Facility	1
Nash	Impact One	2
	Men's Christian Fellowship	1

**Table 10: Citations Reported for Private Group Homes, and Outpatient and Day Treatment Facilities (Continued)**

County	Facility	# Citations
New Hanover	Mims Manor LLC	2
	Woodbridge Alternative at Ilex	1
Onslow	Martha's Group Home	1
Orange	The Hive	2
Pasquotank	West Main House	1
Pitt	Avent Supervised Living	2
	Carolina Support Services	1
	Divine Guidance Interventions	1
	Emmanuel Residential Facility	1
	Health Plus Therapeutic Services	2
	Height Home, LLC	1
	Infinity Options	1
	My Savior Family Care Home	3
	Pentecostal Temple Residential	2
	Red Oak	1
Polk	Pavilion International	1
Randolph	Randleman House	2
Robeson	Bridges Group Home	1
	Hope Community Home	1
	Hope House	3
	Life Solutions Meadowbrook	1
	Life Solutions Timberwood	3
Rowan	Betty Home	2
	Bridging to Success	1
	Fresh Start Boundary House	1
	Liberty Group Home	2
	Sedgefield Home	2
	The Ark	1
	Youth Care, LLC	1
Rutherford	Joyful Too	1
	Reynolds Youth Home	3
Sampson	Lewis Treatment Facility	1
Shelby	Eastpointe Children's Home	1
Stanly	Lafayette Group Home	1
Stokes	Serendipity House	2
Surry	Hunter House	1
	The Way Station	1
Union	Fairley Home	1
	Southwood Place	1
	Wingate Home	1
Vance	Charles Street Facility	1
Wake	Ann's	2
	Azalea Gardens Mental Health Facility	1
	Eastern Wake Home for Adolescents	1
	Harmony Home	1
	Havering Place	1
	Leone Star	1
	Kara Two	1
	K&J Residential	1

**Table 10: Citations Reported for Private Group Homes, and Outpatient and Day Treatment Facilities (Continued)**

Facility		# Citations
Wake (Continued)	Meeks #2	1
	Snowcrest	1
	Snowcrest	1
Warren	Gavin and Downey Heavenly Living	2
Washington	Roanoke Developmental Center	1
Watauga	Creeside Group Home	1
Wayne	Center of Love	1
	St. Mary's Inc	2
Wilkes	Wilkes County Vocational	1
	Swain Street Group Home	1
Wilson	Terrace	2
	Wilson County Group Home #3	1
<b>Total</b>	Facility Count: 206	<b>300</b>

**Table 11: Citations Reported for Private Intermediate Care Facilities for the Developmentally Disabled**

County	Facility	# Citations
Forsyth	Horizons-the Arches	1
Jefferson	Thomas Street Group Home	4
Mecklenburg	RHA/Howell's Center-Lakeview	1
Wake	Electra Drive Group Home	2
Watauga	Wildcat Group Home	1
<b>Total</b>	Facility Count: 5	<b>9</b>

**Table 12: Citations Reported for Private Psychiatric Facilities**

County	Facility	# Citations
Duplin	Duplin General Hospital	1
Henderson	Margaret R. Pardee Memorial Hospital	1
Mecklenburg	The Keys of Carolina <sup>1</sup>	1
Onslow	Brynn Marr Hospital	1
Wake	Holly Hill Hospital	1
<b>Total</b>	Facility Count: 5	<b>5</b>

NOTE:

1. This facility was subject to Federal as well as State policies and procedures for restrictive interventions.

**Table 13: Citations Reported for Certain Unlicensed Facilities<sup>1</sup>**

County	Facility	# Citations
	No citations reported for these facilities	
<b>Total</b>	Facility Count: 0	<b>0</b>

NOTE:

1. Includes private facilities not licensed in accordance with G.S. 122C, Article 2; does not include state facilities operating in accordance with G.S. 122 C Article 4, Part 5.

## Restraint/Seclusion Citations Reported for State Facilities

**Table 14: Citations Reported for State Intermediate Care Facilities for the Developmentally Disabled**

County	Facility	# Citations
Lenoir	Caswell Center	1
Wayne	O'Berry Center	1
<b>Total</b>	Facility Count: 2	<b>2</b>

**Table 15: Citations Reported for State Psychiatric Hospitals**

County	Facility	# Citations
Burke	Broughton Hospital	1
Wayne	Cherry Hospital	2
<b>Total</b>	Facility Count: 2	<b>3</b>

**Table 16: Citations Reported for State Alcohol and Drug Abuse Treatment Centers**

County	Facility	# Citations
	No citations reported for these facilities	
<b>Total</b>	Facility Count: 0	<b>0</b>

**Table 17: Most and Least Frequently Reported Citations for Restraint/Seclusion (R/S) at Private Facilities**

Type of Facility	Restraint/Seclusion Citations		
	#	Most Frequently Reported	Least Frequently Reported
<b>LICENSED ASSISTED LIVING</b>	19	<ul style="list-style-type: none"> <li>• Inappropriate use of R/S (9 citations)</li> <li>• Inadequate assessment/care planning (4 citations)</li> </ul>	<ul style="list-style-type: none"> <li>• Failure to obtain informed consent (1 citation)</li> <li>• Inadequate documentation of R/S (1 citation)</li> </ul>
<b>GROUP HOME &amp; OUTPATIENT DAY TREATMENT</b>	300	<ul style="list-style-type: none"> <li>• Inadequate training on alternatives to restrictive interventions (96 citations)</li> <li>• Inadequate training in R/S and isolation time out (78 citations)</li> </ul>	<ul style="list-style-type: none"> <li>• Prohibited R/S procedure (1 citation)</li> <li>• Noncompliance with general R/S policies (2 citations)</li> </ul>
<b>Intermediate Care Facilities for the Developmentally Disabled</b>	9	<ul style="list-style-type: none"> <li>• Failure to record R/S checks and usage (3 citations)</li> <li>• Failure to ensure that no other option was available or effective before using restraint (2 citations)</li> </ul>	<ul style="list-style-type: none"> <li>• Failure to ensure that a consumer placed in a restraint was released as quickly as possible (1 citation)</li> </ul>
<b>Psychiatric Treatment</b>	5	<ul style="list-style-type: none"> <li>• Failure to document or inadequate documentation on the use of restraints (2 citations)</li> </ul>	<ul style="list-style-type: none"> <li>• Inadequate assessment and care planning (1 citation)</li> <li>• Inappropriate professional performing the one-hour assessment (1 citation)</li> <li>• Failure to use proper R/S technique (1 citation)</li> </ul>
<b>Certain Unlicensed Facilities<sup>1</sup></b>	0	• No citations reported for these facilities	

**NOTE:**

1. Includes private facilities not licensed in accordance with G.S. 122C, Article 2; however, it does not include state facilities operating in accordance with G.S. 122 C Article 4, Part 5.

**Table 18: Most and Least Frequently Reported Citations for Restraint/Seclusion (R/S) at State Facilities**

<b>Type of Facility</b>	<b>Restraint/Seclusion Citations</b>		
	<b>#</b>	<b>Most Frequently Reported</b>	<b>Least Frequently Reported</b>
<b>Intermediate Care Facilities for the Developmentally Disabled</b>	2	<ul style="list-style-type: none"> <li>• Failure to specify the use of physical restraints in the individual program plan (2 citations)</li> </ul>	
<b>Psychiatric Hospitals</b>	3	<ul style="list-style-type: none"> <li>• Failure to communicate among staff performing physical restraint (1 citation)</li> <li>• Failure to use proper restraint technique (1 citation)</li> <li>• No medical doctor's order (1 citation)</li> </ul>	
<b>Alcohol and Drug Abuse Treatment Centers</b>	0	<ul style="list-style-type: none"> <li>• No citations reported for these facilities</li> </ul>	

## **SUMMARY ON RESTRAINT/SECLUSION CITATIONS FOR SFY2006-2007**

A total of 338 citations were reported for 233 private and 4 state facilities for noncompliance with restraint/seclusion policies and procedures:

- 333 of these citations were reported for private facilities; and
- 5 of these citations were reported for state facilities.

The types of facilities with the most number of citations were:

- Private Group Homes, and Outpatient and Day Treatment (300 citations); and
- Private Assisted Living (19 citations).

The most frequently reported citations included the following:

- Inadequate training on alternatives to restrictive interventions; and
- Inadequate training in seclusion, physical restraint, and isolation time-out.

The following corrective actions were taken to address the citations:

- Plans were developed at facilities with the most serious citations; and
- Follow-up monitoring was conducted to verify that plans were implemented.